STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814
(916) 322-5387

July 26, 1982

ALL-COUNTY INFORMATION NOTICE I- 92-82

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: REVISED FORM CA 2 (STATEMENT OF FACTS SUPPORTING ELIGIBILITY FOR ASSISTANCE)
REFERENCE: ACIN I-07-82 AND I-34-82

Attached is a copy of the revised CA 2 (Statement of Facts Supporting Eligibility for Assistance) and a listing of all the changes made to the form since the last revision.

This revision takes into consideration changes required by state AFDC regulations (Parts I and II) implementing the provisions of the Federal Omnibus Budget Reconciliation Act of 1981 and SB 633.

Input for the revision of the CA 2 was received from a variety of sources including individual suggestions from various counties, the County Welfare Directors Association Subcommittee on Food Stamp Forms and the AFDC County Forms Advisory Committee.

Significant changes made to the CA 2 are:

1. Made language changes to the Coversheet to clarify certain areas, e.g., age requirements and pregnancy.

2. Added a section to collect information on anyone who has applied and/or has received public assistance in the past.

3. Added a section to collect information on anyone who wants to request aid and/or a special need payment because of pregnancy.

4. Added a section to identify persons who are aliens and have been sponsored by an individual.

5. Added a section to collect information on anyone who is on a labor strike.

6. Revised Section 9 to collect work history information on both parents in the home.

7. Revised Section 12 to collect employment information for two persons.

8. Rearranged numerical sequence of Sections 13 through 17.

9. Added Section 21 for food stamp applicants.

The addition of Section 21 will eliminate the need to provide an applicant/recipient with the CA 2 FS supplement if the "no" box is checked.

The attached copy of the CA 2 is provided for counties that do their own printing and to allow for training of staff. Regular supplies of the CA 2 are expected to be available by mid-September 1982, from the DSS warehouse. Orders for this revision will be accepted after September 1, 1982, via the GEN 727B, County Forms Order.

A Spanish translation of the CA 2 should be available within a month of the English. If you want a camera ready copy of the Spanish form, please submit your request to:

AFDC Forms Coordinator
AFDC Program Systems Bureau
744 P Street, M.S. 16-31
Sacramento, CA 95814

Regular supplies of the Spanish CA 2 are expected to be available by mid-October 1982.

As with all state AFDC forms, an open file is maintained in order to receive recommendations and suggestions for future forms improvements. If you have any suggestions or comments, please provide them in written form to the AFDC Forms Coordinator. If you have questions about the revised CA 2, please contact your AFDC Program Management Consultant at (916) 445-4458. Questions relating to the use of the CA 2 for food stamps should be directed to your Food Stamp Program Consultant at (916) 322-3141. Questions relating to the use of the CA 2 for the Refugee or Entrant Cash Assistance Programs should be directed to your Refugee Program Consultant at either (916) 322-3141 or (415) 557-8588.

Sincerely,

KYLE S. McKINSEY
Deputy Director

Attachments

cc: CWDA

Item 12

- Revised section to collect employment information on two persons (A1, A2)
- Added the phrase "(Note: if self-employed, list and explain business expenses on a separate sheet of paper and attach to this form)"
- Added a section to report days and hours worked per month
- Removed all sections referring to work-related expenses
- Revised child care question
- Revised child support question

County Use Column

- Revised corresponding areas for each of the items to enable workers to document responses more efficiently

Page 5

Item 15 (formerly item 13)

- Included an example of a new resource - "cash (on hand or elsewhere)" and rearranged order of "resources"

Item 16

- Added "Mobile Homes" to list of personal property examples

Item 17 (formerly 14)

- Added "... Dental, Vision, Other" to 17 C

Item 18

- Provided more space for explanation

County Use Column

- Revised and added corresponding areas for each of the items to enable workers to document responses more efficiently

Page 6

- Added item 21
- Added "caretaker relative" to signature block
- Deleted "other adult recipient" from second signature block

Social Services Section

- Deleted AFDC from the first sentence and inserted "cash aid"
- Added "... Medical or Dental ... "to A2
- Reworded B
- Reworded C

County Use Only (Summary Section) Check List:

- Added "pregnancy verified"
- Added "sponsored alien requirements met"
- Added "school requirements met"
- Added "federal financial participation requirements met"
- Added "employment/earnings verified"
- Deleted "liquid" resources and combined with "personal" and "real property" statement, i.e., "Total real/personal property . . . "

Important Information for Applicants and Recipients of AFDC and Other Cash Aid Programs

Information requested on the attached CA 2 form is necessary to determine your eligibility for Aid to Families with Dependent Children (AFDC), Refugee/Entrant Cash Aid and Food Stamps.

Read the information below explaining your rights and responsibilities before completing the form (CA 2).

If you do not understand some of this information or any of the questions on the form, ask your eligibility worker for help.

You should also read the "AFDC Recipient Handbook" (available through the welfare department) so that you can better understand the AFDC program.

Your Rights as an Applicant or Recipient

- To have your cash aid eligibility determined within a maximum of 45 days.
- To apply for an immediate need cash payment at any time during the processing of your application if an emergency situation arises.
- To be notified in writing, usually at least ten days before the effective date of reduction, discontinuance or change in your grant.
- To voluntarily register for employment services if you are not required to register as a condition of eligibility.
- To be served without regard to race, color, national origin, religion, political affiliation, marital status, sex, handicap, or age; and to file a complaint should you feel you have been discriminated against.
- To discuss any action regarding your case with the welfare department any time you are dissatisfied.
- To request a state hearing if you are dissatisfied with any action taken by the welfare department.
- To be treated with courtesy, consideration and respect.
- To have your records kept confidential by the welfare department.
- To be informed of your rights and responsibilities.
- To receive aid without interruption when you move from one county to another if you remain eligible.

Please See Reverse Side

Your Responsibilitie as an Applicant or Re ipient

You must report the following kinds of changes to the County Welfare Department within 5 days of occurrence and on your Monthly Eligibility Report (CA 7). Be sure to report when:

- You receive money from work, relatives, social security, veterans' benefits, tax refunds, or any other source.
- You begin or stop work or training.
- You begin to receive free rent or utilities where you live.
- Your income increases, decreases, starts or stops.
- You get or dispose of real estate or personal property, including purchase or sale of homes, vehicles, etc.
- Your child(ren) age 16, 17 or 18 begins or drops out of school or training.
- You or your spouse terminate a pregnancy for which you are receiving benefits.
- Someone moves into or out of your home (including your children).
- You move to another address, or visit outside the county or state for more than 30 days.
- You get married, become separated, or divorced.
- You reunite with your spouse or the absent parent returns to the home.

If you aren't sure that a change should be reported, contact your eligibility worker. If you receive aid for which you are not eligible, you may have to repay it.

Social Security Number

You must furnish or cooperate in securing a verifiable Social Security Number for each person for whom you are applying. Furnishing of the Social Security Number is a condition of eligibility required by Section 402(a)(25) of the Social Security Act. The number will be used when coordinating information with other public agencies.

If you cannot furnish a Social Security Number for all persons for whom you are applying, you must cooperate in securing a number(s) by applying directly to the Social Security Administration, providing proof of application, and providing the number(s) to the county welfare department when received.

I certify that I have been informed of my rights and responsibilities as stated above, and am aware of the possibilities of criminal penalties for making false statements or failing to report information or situations which may affect my eligibility or aid payment.

Signature of Applicant _____ Date _____

Signature of Spouse or Other Parent _____ Date _____

I certify that I have informed the applicant or recipient of his or her rights and responsibilities as stated above and of the possibilities of criminal penalties for making false statements or failing to report information or situations which affect his or her eligibility or aid payment.

Eligibility Worker's Signature _____ Eligibility Worker's Number _____ Date _____

State of California
Health and Welfare Agency

Department of Social Services

STATEMENT OF FACTS SUPPORTING ELIGIBILITY FOR ASSISTANCE

INSTRUCTIONS: *Complete all questions in ink (black preferred). If you have any problems with any questions, leave them blank and your eligibility worker will help you. Use receipts and records to help you answer questions, and bring them with you to the interview to support your answers. Questions asking about "you or your family" refer to all persons for whom you are requesting aid.*

COUNTY USE ONLY

Deprivation Verification	FFP Status: (Fed., Non-Fed., Essen. Pers)	Age Verification	Work Reg - MA 5-95 Gen 827 or exempt. code.	Citizenship/Alien Verification/Status

(1) **APPLICANT'S NAME (First, Middle Initial, Last)** | TELEPHONE NUMBER ( ) –

HOME ADDRESS (IF YOU DO NOT HAVE A HOUSE NUMBER ON A CITY STREET, GIVE DIRECTIONS TO YOUR HOUSE OR ATTACH A MAP)

MAILING ADDRESS (IF DIFFERENT THAN HOME ADDRESS - NUMBER, STREET, CITY, STATE, ZIP CODE)

(2) **A. HAVE YOU OR YOUR FAMILY APPLIED FOR OR RECEIVED PUBLIC ASSISTANCE IN THE PAST?** If YES, complete: ☐ YES ☐ NO

Who Applied?	Where	Date Applied	Type of Aid (AFDC, Food Stamps, Medi-Cal, Refugee, Entrant, etc.)
Who Received Aid?	**Where**	**Last Date of Aid**	**Type of Aid (AFDC, Food Stamps, Medi-Cal, Refugee, Entrant, etc.)**

(2) **B. LIST ALL PERSONS FOR WHOM YOU ARE REQUESTING AID.**

1. APPLICANT'S NAME (First, Middle Initial, Last)

SOCIAL SECURITY NUMBER | CIRCLE SEX M F | BIRTHPLACE (CITY, STATE) | BIRTHDATE / /

ARE YOU A CITIZEN OF THE UNITED STATES? YES ☐ NO ☐

PRESENT MARITAL STATUS? (CHECK ONE)
☐ MARRIED ☐ NEVER MARRIED
☐ SEPARATED ☐ DIVORCED
☐ COMMON LAW MARRIAGE ☐ WIDOWED

CHILDREN NEED AID BECAUSE OF PARENT'S: (CHECK ✓ BELOW)
ABSENCE | UNEMPLOYMENT | INCAPACITY | DEATH

2. NAME OF SPOUSE OR OTHER PARENT

SOCIAL SECURITY NUMBER | CIRCLE SEX M F | BIRTHPLACE | BIRTHDATE / /

U.S. CITIZEN? YES ☐ NO ☐

☐ MARRIED ☐ NEVER MARRIED
☐ SEPARATED ☐ DIVORCED
☐ COMMON LAW MARRIAGE ☐ WIDOWED

3. NAME OF CHILD

SOCIAL SECURITY NUMBER | CIRCLE SEX M F | BIRTHPLACE | BIRTHDATE / /

U.S. CITIZEN? YES ☐ NO ☐

MOTHER'S NAME
FATHER'S NAME
CHILD LIVING IN YOUR HOME? ☐ YES ☐ NO
IF NO, GIVE REASON

4. NAME OF CHILD

SOCIAL SECURITY NUMBER | CIRCLE SEX M F | BIRTHPLACE | BIRTHDATE / /

U.S. CITIZEN? YES ☐ NO ☐

MOTHER'S NAME
FATHER'S NAME
CHILD LIVING IN YOUR HOME? ☐ YES ☐ NO
IF NO, GIVE REASON.

5. NAME OF CHILD

SOCIAL SECURITY NUMBER | CIRCLE SEX M F | BIRTHPLACE | BIRTHDATE / /

U.S. CITIZEN? YES ☐ NO ☐

MOTHER'S NAME
FATHER'S NAME
CHILD LIVING IN YOUR HOME? ☐ YES ☐ NO
IF NO, GIVE REASON.

6. NAME OF CHILD

SOCIAL SECURITY NUMBER | CIRCLE SEX M F | BIRTHPLACE | BIRTHDATE / /

U.S. CITIZEN? YES ☐ NO ☐

MOTHER'S NAME
FATHER'S NAME
CHILD LIVING IN YOUR HOME? ☐ YES ☐ NO
IF NO, GIVE REASON

7. NAME OF CHILD

SOCIAL SECURITY NUMBER | CIRCLE SEX M F | BIRTHPLACE | BIRTHDATE / /

U.S. CITIZEN? YES ☐ NO ☐

MOTHER'S NAME
FATHER'S NAME
CHILD LIVING IN YOUR HOME? ☐ YES ☐ NO
IF NO, GIVE REASON

(2) C. DO ANY OF THE PERSONS LISTED IN (2) B WISH TO RECEIVE AID BECAUSE OF PREGNANCY? ☐ YES ☐ NO

If YES, complete:

WHO	EXPECTED DATE OF BIRTH	FATHER'S NAME

CHECK THE APPROPRIATE BOX(ES) THAT APPLIES TO THE FATHER OF THE UNBORN CHILD:

☐ ABSENT ☐ UNEMPLOYED ☐ INCAPACITATED ☐ DECEASED

(2) D. ARE ANY OF THE PERSONS LISTED IN (2) B ALIENS? ☐ YES ☐ NO

If YES, complete:

WHO	DATE ALIEN ENTERED U.S	DOES THIS PERSON HAVE AN INDIVIDUAL SPONSOR?
		☐ YES ☐ NO
WHO	DATE ALIEN ENTERED U.S	DOES THIS PERSON HAVE AN INDIVIDUAL SPONSOR?
		☐ YES ☐ NO

(3) LIST ALL OTHER PERSONS LIVING IN YOUR HOME.

Name (First, Middle Initial, Last)	Age	Sex M/F	Relationship to Children	Does Person Have Income?
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

(4) DO YOU AND ALL MEMBERS OF YOUR FAMILY FOR WHOM YOU ARE REQUESTING AID PRESENTLY LIVE IN CALIFORNIA AND INTEND TO CONTINUE LIVING HERE? ☐ YES ☐ NO

(5) IF THE OTHER PARENT(S) OF THE CHILD(REN) DOES NOT LIVE WITH YOU, GIVE THE REASON:
(Divorced, separated, employment away from home, military, etc.)

(6) ARE YOU OR ANYONE IN YOUR FAMILY (16 years and over) **PRESENTLY ATTENDING SCHOOL OR A TRAINING PROGRAM?** If YES, complete the following: ☐ YES ☐ NO

Name	Age	Name of School or Training Program	Attending Full Time?	Expected Date of Graduation	Employed?
			☐ YES ☐ NO		☐ YES ☐ NO
			☐ YES ☐ NO		☐ YES ☐ NO
			☐ YES ☐ NO		☐ YES ☐ NO
			☐ YES ☐ NO		☐ YES ☐ NO

(7) HAVE YOU BEEN IN THE MILITARY SERVICE OR ARE YOU THE SPOUSE, PARENT OR CHILD OF A PERSON WHO HAS BEEN IN THE MILITARY SERVICE? ☐ YES ☐ NO

(8) A. HAVE EITHER OF THE CHILD(REN)'S PARENTS LIVING IN THE HOME QUIT OR REFUSED A JOB OR TRAINING WITHIN THE LAST 30 DAYS? If YES, complete below. ☐ YES ☐ NO

PARENT'S NAME	AMOUNT OF LAST PAY CHECK	LAST DAY OF JOB/TRAINING MONTH / DAY / YEAR	HOURS OF WORK/TRAINING IN LAST 30 DAYS
	$		

NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM	REASON FOR LEAVING OR REFUSAL

(8) B. ARE YOU OR ANYONE IN YOUR FAMILY PARTICIPATING IN A LABOR STRIKE? ☐ YES ☐ NO

If YES, complete:

WHO:	DATE PERSON WENT ON STRIKE:

COUNTY USE ONLY

☐ *Special Need Requested*
☐ *Medical Verification Received:* _____
☐ *CA 22*
☐ *Stepparent*
☐ *CA 71 (UAM)*
☐ *CA 2.1*
☐ *CA 371*

SCHOOL ATTENDANCE VERIFIED

☐ *YES* ☐ *NO*
☐ *YES* ☐ *NO*
☐ *YES* ☐ *NO*
☐ *YES* ☐ *NO*

☐ *CA 5*
☐ *Employer Statements*
☐ *Determination of Good Cause Required*
☐ *Striker(s)*

(9) COMPLETE THE FOLLOWING FOR THE CHILD(REN)'S PARENT(S) WHO IS/ARE LIVING IN THE HOME:

A. FIRST PARENT - (Name: _____). List employment and training history for the past 5 years. Begin with this person's last job or training.

	Name of Employer or Training Program	Work or Training ✓ Check	When Employed From / / MO DAY YR To	Amount Paid		Name of Employer or Training Program	Work or Training ✓ Check	When Employed From / / MO DAY YR To	Amount Paid
1.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	7.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
2.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	8.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
3.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	9.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
4.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	10.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
5.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	11.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
6.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	12.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly

(9) B. SECOND PARENT OR OTHER SPOUSE for whom aid is requested (Name _____).
List employment and training history for the past 5 years. Begin with this person's last job or training:

	Name of Employer or Training Program	Work or Training ✓ Check	When Employed From / / MO DAY YR To	Amount Paid		Name of Employer or Training Program	Work or Training ✓ Check	When Employed From / / MO DAY YR To	Amount Paid
1.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	7.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
2.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	8.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
3.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	9.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
4.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	10.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
5.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	11.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly
6.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly	12.		☐ Work ☐ Training	From / / To / /	$ ☐ Weekly ☐ Monthly

(9) C. HAS EITHER PERSON LISTED IN (9) A or (9) B RECEIVED UNEMPLOYMENT INSURANCE BENEFITS (UIB) WITHIN THE LAST 12 MONTHS? ☐ YES ☐ NO
If YES, complete:

	Name of Person	Dates Received
1.		
2.		

COUNTY USE ONLY

First Parent's Earnings

YEAR	QUARTER Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec
	EARNINGS			
	$			
	0			
	$			

Total Earnings $ _____

YEAR	QUARTER Jan-Mar		Apr-Jun		July-Sept		Oct-Dec	
	$50	Trng.	$50	Trng.	$50	Trng.	$50	Trng.

☐ Quarters _____

Second Parent's Earnings

YEAR	QUARTER Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec
	EARNINGS			
	$			
	$			
	$			

Total Earnings $ _____

Principal Earner:
☐ *1st* ☐ *2nd Parent*

YEAR	QUARTER Jan-Mar		Apr-Jun		July-Sept		Oct-Dec	
	$50	Trng.	$50	Trng.	$50	Trng.	$50	Trng.

☐ *Quarters* _____

UIB:
☐ *Eligible* ☐ *Referral*
☐ *Eligible* ☐ *Referral*
☐ *Fed* ☐ *Non Fed*

(10) DO YOU OR YOUR FAMILY RECEIVE OR ECT TO RECEIVE INCOME FROM ANY OF THE FOLLOWING SOURCES? Check each item. If YES, explain below.

	YES	NO
A. Public Assistance [SSI/SSP, (Gold Checks), General Assistance, aid from another county/state, etc.]	☐	☐
B. Child/Spousal Support	☐	☐
C. Unemployment or Disability Insurance/ Worker's Compensation	☐	☐
D. Veterans' or GI Benefits, Military Allotments	☐	☐
E. Social Security, Railroad Retirement	☐	☐
F. Retirement Pensions	☐	☐
G. Self-Employment or Farm (attach explanation)	☐	☐
H. Training Allowance	☐	☐
I. Contributions, Cash Gifts	☐	☐
J. Rental of Land, Buildings, Vehicles (attach explanation and details)	☐	☐
K. Sale of Property (Trust Deeds)	☐	☐
L. Loans, Payments (on your behalf)	☐	☐
M. Tax Refunds	☐	☐
N. Public Retirement, Vacation Pay	☐	☐
O. Legal or Accident Settlements Pending	☐	☐
P. Strike Benefits	☐	☐
Q. Money for Care of Foster Child	☐	☐
R. Interest, Dividends, Royalties	☐	☐
S. Scholarships, Grants, Loans for School	☐	☐
T. Earned Income Credit	☐	☐
U. Other (specify)_____	☐	☐

Name of Person Receiving Income	Source of Income	Date Received (or expected)	Amount	How Often? (weekly, mo.)

(11) DO YOU OR YOUR FAMILY RECEIVE ANY OF THE FOLLOWING FREE OR IN EXCHANGE FOR WORK THAT YOU DO? Check each item. If YES, explain below.

Item Received	Yes	No	Name of Person Receiving Item	Received from Whom	Value of Item
A. Housing or Rent	☐	☐			
B. Utilities	☐	☐			
C. Food	☐	☐			
D. Clothing	☐	☐			

(12) A. ARE YOU OR IS ANYONE IN YOUR FAMILY PRESENTLY WORKING OR EXPECT TO BE WORKING WITHIN THE NEXT TWO MONTHS? If YES, complete the following: ☐ YES ☐ NO

(**Note:** If self-employed, list and explain business expenses on a separate sheet of paper and attach to this form)

A1 NAME OF PERSON WORKING | SELF EMPLOYED? ☐ YES ☐ NO | NAME OF EMPLOYER | OCCUPATION

DAYS/HOURS WORKED PER MONTH

HOW OFTEN IS THE PERSON WORKING PAID? (CHECK ONE AND ENTER AMOUNT PAID)
☐ Monthly $_____ ☐ Weekly $_____ ☐ Every two weeks $_____
☐ Twice a Month $_____ ☐ Other (explain) $_____

DOES THE PERSON WORKING RECEIVE ANY OTHER MONEY, SUCH AS TIPS, COMMISSIONS, ETC.?
☐ YES ☐ NO If YES, explain:

HOW MUCH? $ Per

A2 NAME OF PERSON WORKING | SELF EMPLOYED? ☐ YES ☐ NO | NAME OF EMPLOYER | OCCUPATION

DAYS/HOURS WORKED PER MONTH

HOW OFTEN IS THE PERSON WORKING PAID? (CHECK ONE AND ENTER AMOUNT PAID)
☐ Monthly $_____ ☐ Weekly $_____ ☐ Every two weeks $_____
☐ Twice a Month $_____ ☐ Other (explain) $_____

DOES THE PERSON WORKING RECEIVE ANY OTHER MONEY, SUCH AS TIPS, COMMISSSIONS, ETC.?
☐ YES ☐ NO If YES, explain:

HOW MUCH? $ Per

(12) B. IF YOU MUST PAY FOR CARE FOR A CHILD OR INCAPACITATED ADULT WHILE YOU WORK, COMPLETE THE FOLLOWING:

Name of Dependent	Amount Paid	Paid By Whom
	$ ☐ Monthly ☐ Weekly	
	$ ☐ Monthly ☐ Weekly	
	$ ☐ Monthly ☐ Weekly	

IS THERE ANYONE IN THE HOUSEHOLD WHO CAN PROVIDE THE CARE?
☐ YES ☐ NO

IF YES, WHO? AND WHAT IS THEIR RELATIONSHIP TO YOU? (MOTHER, SISTER, ETC.)

(12) C. DOES ANYONE IN YOUR FAMILY PAY CHILD OR SPOUSAL SUPPORT? ☐ YES ☐ NO

Who Pays? How Much? For Whom?

COUNTY USE ONLY

INCOME/BENEFITS VERIFIED:
- ☐ *SSA 1610/CA 810*
- ☐ *CA 5*
- ☐ *Other:*

INKIND INCOME

Full	*Partial*	*Earned*	*Unearned*

Total Value: $_____

EARNINGS AND EXPENSES VERIFIED:
- ☐ *Self Employment Worksheet*
- ☐ *Wage Stubs*
- ☐ *UIB Referral*
- ☐ *Tips expected:*
- ☐ *Self Employment Worksheet*
- ☐ *Wage Stubs*
- ☐ *UIB Referral*
- ☐ *Tips expected:*
- ☐ *Dependent Care Verified*
- ☐ *Viewed Court Order*

Amount of Order $_____
Date of Order _____
County, State _____

☐ *Petition to Court 44-113.9*

(13) DO YOU OR YOUR FAMILY OWN OR ARE OR YOUR FAMILY BUYING REAL ESTATE? ☐ YES ☐ NO

If YES, list all land and buildings (including your house) that you own, have title to or share title in.

Type (Land, house, apartment, etc.)	Use (Home, income, investment)	Address or Location	Owner(s)	Name of Mortgage Co	Amt. Owed

(14) DO YOU OR YOUR FAMILY OWN OR USE ANY MOTOR VEHICLES? ☐ YES ☐ NO

If YES, complete the following:

Owner of Vehicle	Name of Person Who Uses Vehicle	Year, Make and Model	License No. and State of Registration	Mo. Payment	Bal. Owed
				$	$
				$	$
				$	$

(15) DO YOU OR YOUR FAMILY HAVE ANY OF THE RESOURCES LISTED BELOW?

Check each item. If YES, explain below.

	YES	NO
A. Checks (at home or elsewhere)	☐	☐
B. Cash (on hand or elsewhere)	☐	☐
C. Savings Account	☐	☐
D. Checking Account	☐	☐
E. Credit Union Account	☐	☐
F. Notes, Mortgages, Trust Deeds, Sales Contracts	☐	☐
G. Trust Fund	☐	☐
H. Stocks, Bonds or Certificates	☐	☐
I. Other resources which can be quickly changed into cash (specify) _____	☐	☐

Type of Resource	Owner	Current Value	Name and Address of Banks, Etc.	Account Number
		$		
		$		
		$		

(16) DO YOU OR YOUR FAMILY OWN OR USE PERSONAL PROPERTY WHICH COST AT LEAST $100 FOR EACH ITEM OR ARE NOW WORTH AT LEAST $100 EACH? ☐ YES ☐ NO

If YES, list such things as: mobile homes, boats, campers, recreational equipment, farm equipment, tools, livestock, trailers, musical equipment, jewelry, etc. Do not list: clothing, wedding rings, rugs, furniture, appliances, televisions, other household furnishings.

Name of Item	Date of Purchase	Purchase Price If a Gift Check (✓) Box	Amt. Owed
		$ Gift ☐	
		$ Gift ☐	
		$ Gift ☐	
		$ Gift ☐	

(17) DO YOU OR YOUR FAMILY HAVE ANY OF THE FOLLOWING INSURANCE COVERAGES?

Check each item. If YES, explain below.

	YES	NO
A. Life	☐	☐
B. Burial	☐	☐
C. Medical/Health, Dental, Vision, Other	☐	☐
D. Mortgage	☐	☐

Name of Insurance Company	Policy Number	Persons Covered (Names)	Premium Paid by (Name)	Amount Paid	How Often Paid
				$	
				$	
				$	

(18) HAVE YOU OR YOUR FAMILY SOLD, TRANSFERRED OR GIVEN AWAY ANY REAL ESTATE OR PERSONAL PROPERTY WITHIN THE LAST 2 YEARS? ☐ YES ☐ NO

If YES, explain what and when:

COUNTY USE ONLY

☐ *Home Exempt*

Other Real Property:

Market Value $ _____

Less Allowable Encumbrances $ _____

Net Value $ _____

☐ *MV Registration Viewed*

	1	2
Class/Value		
Less Encumbrances –		
Net Value =		
$1500 Exemption (1 MV only)		
Total Value $		

Excess Value $ _____

☐ *Total Value Verified:*

$ _____

☐ *Exempt as home, specify:*

Net Market Value
$

Total Personal Property Value

☐ *Coverage Code:* _____

☐ *Health Care Coverage Questionnaire*

Total CSV $ _____

Total of Items (13-17)

$ _____